STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120476-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 30th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On April 6, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 14, 2011.

The petitioner receives health care coverage through his employer's Blue Cross Blue Shield of Michigan (BCBSM) benefit plan. The contract is the BCBSM *Community Blue Group Benefits Certificate* (the certificate) as amended by *Rider CBD $5000-P (Community Blue Deductible Requirement For Panel Services.)*

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On November 7, 2010, Petitioner's employer notified its employees that their deductible would be increased from $3,000 to $5,000 per year. On December 3, 2010, the Petitioner had hernia repair surgery. BCBSM provided coverage for the surgery applying $2,000 to the newly-increased $5,000 calendar deductible.

The Petitioner appealed BCBSM's application of the higher deductible to his December 3, 2010, surgery. After a managerial-level conference on March 14, 2011, BCBSM maintained its determination and issued a final adverse determination dated March 30, 2011.

III. ISSUE

Did BCBSM correctly apply $2,000 to Petitioner's $5,000 deductible under the terms of the certificate?

IV. ANALYSIS

Petitioner's Argument

On November 16, 2010, Petitioner was diagnosed with a hernia that required surgical repair. Petitioner states that on November 17, 2010, he contacted BCBSM's customer service department and specifically asked if his deductible would remain the same for the calendar year. Petitioner states he told BCBSM's customer service representative that he would wait to schedule his surgery in December if the deductible limit was not going to change but he would schedule the surgery for November if it was going to change. The Petitioner indicates that the representative told him that the deductible limit was valid until the end of the year (or December 31, 2011).

The Petitioner's surgery was scheduled for December 3, 2010. Petitioner states he again called BCBSM and was told that there would be no out-of-pocket expense. Petitioner argues that he could have scheduled surgery for November 29 or 30, 2011, but chose the December date because he was told by BCBSM representatives that his deductible limit was valid through the end of the year and it meant he would miss fewer work days. Petitioner maintains that " both of my calls to Blue Cross came after they were notified by my [employer] to raise our deductible on the renewal date."

The Petitioner contends his December 3, 2010, surgery should not be subject to the $5,000 deductible as charged but rather to the original $3,000 deductible which he had already met. Petitioner argues that BCBSM gave him incorrect information and he should not have to pay the higher deductible for relying on that information.

BCBSM's Argument

BCBSM states that coverage is provided to the Petitioner under the *Community Blue group Benefits Certificate* as amended by *Rider CBD $5,000-P*. This rider took effect on the date of plan renewal, December 1, 2010. *Rider CBD $5,000-P* (which requires a deductible of $5,000 for one member or $10,000 for a family) replaced *Rider CBD $3,000-P* (which required a deductible of $3,000 for one member or $6,000 for a family). This replacement effectively raised the Petitioner's annual deductible requirement from $3,000/$6,000 to $5,000/$10,000.

BCBSM argues that the information their customer service department gave the Petitioner was correct at the time given. BCBSM's appeals unit staff member wrote in the final adverse determination that "benefits changes are put in place by [a plan's] effective date when the notice is received within a reasonable time period prior to the effective date of the changes requested. Had you called in December and prior to your surgery, I am confident that you would have been informed of the additional deductible requirement for the 2010 benefit year."

BCBSM argues the notice of change was received on November 8, 2010, meeting the above requirement of "within a reasonable time."

Commissioner's Review

Rider CBD $5000-P includes the following provision:

> **The "What You Must Pay" section of your certificate is amended to add the following deductible requirements for panel services:**
>
> **Deductible Requirements**
>
> Panel Providers
>
> You are required to pay the following deductible each calendar year for covered services provided by panel providers:
>
> $5,000 for one member
>
> $10,000 for the family (when two or more members are covered under your contract) [Underlining added for emphasis.]

Petitioner believes that his December 3, 2010, surgery should not be subject to the additional $2,000 deductible requirement because he was misinformed by BCBSM and relied on the information given. BCBSM contends the information given to the Petitioner was correct when it was given.

The Commissioner cannot resolve this factual dispute about whether or not BCBSM misinformed the Petitioner. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether BCBSM properly administered health care benefits under the terms and conditions of the applicable insurance certificate and relevant state law. Resolution of factual disputes such as the one described by the Petitioner cannot be part of a PRIRA review because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements. The Commissioner cannot resolve this factual dispute about whether or not BCBSM misinformed the Petitioner.

The Commissioner finds that BCBSM's application of $2,000 toward the $5,000 calendar year deductible was consistent with the rider and was, therefore, a correct application of the terms of the Petitioner's benefit plan.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of March 30, 2011, is upheld. BCBSM is not required to waive the $2,000 applied to the Petitioner's deductible.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.